Library

SECOND SERIES VOL. V, No. 8

BULLETIN

OF

THE NEW YORK ACADEMY OF MEDICINE

AUGUST, 1929

INSTITUTED 1847

PUBLISHED MONTHLY BY
THE NEW YORK ACADEMY OF MEDICINE
Fifth Avenue and 103rd Street
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EDITORIAL

DEVELOPMENTAL POSSIBILITIES IN MEDICAL HISTORY AS A BRANCH OF THE MEDICAL CURRICULUM

At the Johns Hopkins University, the conferring of degrees, academic announcements, presidential and other addresses are all included in the ceremonial functions which take place on Washington's Birthday. The address for the present year was delivered by Professor William H. Welch, who now occupies the chair of history of medicine. Dr. Welch spoke at length of recent developments of the subject in Europe and the United States, which have been carefully tabulated by Professor Sigerist (Leipzig),[1] of the consolidation of the three libraries of the Johns Hopkins Medical School, Hospital and School of Hygiene in the new building which bears his name, of the inspiring influence of Osler in activating an interest in the historical approach from the start, and of its important rôle in the academic curriculum, both as a discipline for the mind and as an agency of humanistic culture. If it seem odd, at first sight, that the history of medicine should have acquired the salient, potent and important rôle which Dr. Welch assigned to it, one has only to reflect that the term "medicine" now implies a great array of basic disciplines and specialties, which utilize all phases of applied science and technics and are in close touch with human activity on nearly every side. A history of physics, of

[1] Sigerist: *Kyklos*, Leipz., 1928, I. A similar survey, stressing mainly museum exhibits and medical numismatics, was made by Raphael Blanchard in 1907 (*Bull. Soc. franc. de l'hist. de la méd.*, Par., 1907, vi, 239-280).

chemistry, of mathematics, of mineralogy, geology, or astronomy, for instance, or even of such subjects as geography, naval architecture, commerce, navigation, transportation, philosophy, cookery or lace-making, will have no such broad human interest as this; for medicine, as Goethe said, "occupies the whole man because it is occupied with the entire human organism." Herein, the history of medicine is rivalled only by the history of religions, of literature, of the fine arts and of general human culture (*Culturgeschichte*). Apart from the latter, there is only one other theme of broader scope, namely the history of hygiene, which is as yet undeveloped and as Sudhoff has so cleverly and conclusively shown, starts from fundamental postulates essentially different, requires different lines of approach and attack, another sort of *flair* in exploring a given terrain and *à fortiori* very different means and methods of developing its possibilities. A bedridden human being, disabled by disease or injury, is one thing. How to lessen the possibility of such occurrences is quite another. Here, Sudhoff's great Dresden Catalogue of 1911, with its impressive exhibit of 20,394 individual objects, each a jumping-off place or *point d'appui* for separate research in the history of hygiene, was a revelation as to things undone.

It is proposed herein, not to labor the themes of Dr. Welch's address, but to sketch out a few useful lines of approach, and pedagogic devices which have suggested themselves through occasional contact with medical students and a large correspondence with research workers in need of information. To begin with, intensive study of medical history and its branches is largely a matter for mature physicians, who may have acquired the leisure and financial means necessary for acquisition of essential literature, for private study and for journeyings to European centers. For the medical student, whose business it is to learn how to practice medicine or surgery, to carry on laboratory work, to become a public health officer, to follow other details of applied medicine or sanitation, it is senseless to burden the mind with prosy lectures and

dry details about the medicine of the past. The thing has been attempted more than once and, in nearly every case, has resulted in failure or abandonment, *fiasco fiaschegiando.* If the student's time is to be taken up with this theme at all, it must be made interesting and stimulating to him at the start, by direct, personal lines of approach. Here the wonderful spontaneity, the captivating geniality and contagious enthusiasm of Osler's mentality amounted to positive genius. Whether it were Heberden's nodes or Hutchinson's teeth or Blaud's pills that came up in the clinics, he would ask point-blank: Who was Heberden? Who was Hutchinson? Who was Blaud? An eponym, a *râle,* a method, an instrument became, as in Victor Hugo's definition of a statue, "a nudge to ignorance," not unlike Finlayson's initial question to his classes: "Did Galen write in Greek or Latin and before Christ or after?" To get adequate answers to these simple questions, by their own "original investigations," was Osler's way of inducting students into a new line of study and self-development. The essential was that one should be honest about it and do his own work. And from the simplicity of the Osler-Finlayson plan derives the best advice that can be given to students seeking counsel, *viz.,* study the subject backwards, not from Egypt and Babylon, Hippocrates or Galen, down to our own times, but the other way around, from the known to the unknown, backing into it, so to speak from the most obvious or available angle. Here, Huxley's lecture on "A Piece of Chalk" affords, as Dr. Welch once remarked, one of the most beautiful examples we have of the almost limitless possibilities of a theme suggested by a simple object at hand in every lecture-room or laboratory; a bit of crayon leads into the biology of the Foraminifera and the vast history of geological formations. Rohde's *Psyche,* Salomon Reinach's *Orpheus,* Frazer's *Golden Bough,* Adams' *Chapters of Erie,* Frobenius on Africa, Codrington on the Melanesians, all illustrate the advantages of Gaspar Becerra's lesson,[2] "Take that which lieth nearest," choose a terrain you know something about

[2] See Longfellow's poem.

to start with. How stimulating and vivifying this Osler method may be gathered from an experience related by Ramón y Cajal—the necessity of absolving a course in medical history, in one of the Spanish faculties, upon no other basis than a syllabus of the dismal medical theories of the past as a bolster for some bizarre phase of doctrine entertained by the professor himself! An equally important line of approach for students is suggested by another pathetic anecdote in the Cajal autobiography about a colleague, in the Madrid Medical Faculty, who was intimidated from publishing the results of important experimental work and lost his priority, in more than one instance, through financial inability to purchase current literature and so ascertain if his findings had already been established or confuted by other colleagues. For the medical student, there is no better preliminary course of training for future historical studies than to look up references, to read and report upon special articles in foreign or domestic journals, to learn something of the methods of indexing, classifying and abstracting the periodical literature of medicine, the abbreviations used, and the checks upon accuracy. Here Osler was again forehanded, required such things of his students and fostered a Journal Club. A foreign medical professor, recently visiting the Surgeon General's Library, commented in favorable terms upon the uniform accuracy of the references and bibliographies now found in many recent American medical books and monographs. If this tradition, deriving from the methods initiated by Billings and Fletcher in the Index Catalogue, is to be maintained, the student should be taught how to enter a reference accurately, so as to identify the author (by initials or otherwise), the title or subject of the article, the journal (by the abbreviations employed by the Surgeon General's Library and the American Medical Association), its date, volume or number, and the place of the article in it (by authenticated pagination). To know how to go about this properly is no small matter in itself, suggesting old Theodor Kullak's dictum "It is no small accomplishment in anyone to be

able to play the piano well." Here, at the same time, is a definite pathway into the literary history of medicine or (shall we say) the history of medical literature; for an accurate reference to a basic contribution on metabolism or protein sensitization is quite as important, in its way, as a reference out of Sydenham or the Hippocratic Canon, and thus, at the start, acquires heuristic value. The earlier (first and second) series of the Index Catalogue now constitute, in fact, a vast layout or scaffolding of the literary history of medicine. The third series is taken up almost exclusively with the medical literature of recent years.

Exercises in making bibliographies of special subjects, *e. g.,* of the basic contributions on valvular diseases of the heart or of the writings of prominent contributors to medical literature, will obviously be of great value to students, for it is well that the future doctor should know how such things are to be done, even if eventually delegated to his secretary. Here, as elsewhere, we may take comfort in the maxim of Sir Walter Scott: "The wise man is his own best servant." [3] Bibliographical lists, perfunctorily made by a secretary, or some other hired help, are apt to be self-revealing as to inadequacy or second-hand flavor. An important phase of this kind of work is the capacity to develop, from well-arranged bibliographical lists, certain sidelights on the subject not otherwise accessible and this is particularly true of chronological arrangements of medical writings and of important events. In investigating an unexplored terrain, such as the history of acupuncture, or of town-planning or of the semeiology of an unusual disease, the surest line of approach, the most effective scaffolding, is the chronological layout, which is usually found to project from far-flung lines in the remote past, and has the additional advantage of inducing the student to familiarize himself with the commoner sources of reference. Herein, many unsuspected data may be developed, as from a photographic negative, by the mere juxtaposition of successive steps in an important investigation without reference to

[3] In *The Fortunes of Nigel.*

dates, *e. g.*, in Gaskell's great memoir on the vagus nerve. Many "values" and latent possibilities in this important monograph, seemingly unnoticed or unthought of by the eminent physiologist himself, have latterly been thrown into salient relief through the confirmation of his results by subsequent investigators. This, too, is the first step toward an intelligent reading of the greater medical classics of the past, some of which contain essentially modern ideas, only expressed in the archaic language of the time, and here the finest discrimination is necessary to distinguish between what is really valid intuition and what may be "read into" the text by the reader himself. Another rewarding line of similar tendency is to encourage the student to read the more substantial sort of secular literature with special reference to its sidelights on the medicine of the particular place and period. Examples are plentiful and ready to hand. Investigation of medical details in Homer (Frölich), the Bible, the Latin poets (Dupouy, Menière), in Chaucer, Rabelais, Molière, Shakespeare and the novelists of Victorian England, is become a commonplace. An astounding array of medical data in Cicero alone has been collated in the two fair-sized volumes of Birkholz (1806) and Prosper Menière (1862). Here, the student may "take hold anywhere," from Caesar's Commentaries to the military memoirs of the World War, from Sappho to Swinburne, from the Greek dramatists to Ibsen, from Quintilian to Sainte Beuve, from *Daphnis and Chloe* to the latest novel of sorts, and with the additional advantage of improving his mind by acquainting himself with the literary classics, where he might otherwise be wasting time on some ephemeral trash of the present hour. For many years, the great Library of the Paris Medical Faculty outpaced the Surgeon General's Library in number of volumes,[4] because the old world collection comprised full sets of the greater classics of French literature, which were included on account of the medical lore latent in them. There is hardly any literary work of magnitude which does

[4] As distinguished from pamphlets (less than 100 pages).

not throw some light on the medicine of its period, a fact which stands out in glaring contrast with the singular conspiracy of silence about medicine and medical men only too apparent in the secular historians to date. Wells, in his "History of the World," mentions only Avicenna, but Rhodes, MacMaster and Mark Sullivan are noble exceptions.

Assuming that the pupil has now acquired ways and means of looking up subjects and getting himself interested in them, a further step would be the organization of a medical history club, preferably by the students themselves under guidance of some mentor, as at the Mayo Clinic or the Medical Schools of the George Washington and Georgetown Universities (Washington). Beginning with simple ten-minute biographical papers or extempore talks on different subjects, considerable progress can thus be made in familiarizing a class with the significance of the greater leaders, and the high spots and landmarks in the advancement of medicine. It is important, however, for the precentor or fugleman to penetrate the minds of his fellows with the fact that such contributions are, in the very nature of things, ephemeral and otherwise hardly "fit" for actual publication. Papers on Hippocrates, Harvey, Sydenham, Jenner—these themes have been handled scores of times. With an eye to the great avalanches of medical literature now descending upon us, the inculcation of the *nonum prematur in annum* at the start is highly desirable. The main object of the students' medical history club should be to cover the essential landmarks in the progress of medicine in a way that might be interesting and profitable to themselves. Supplementary to these evenings, a series of lantern slides, arranged as a movie by a recent mechanical invention, can be utilized to bring out the main lines of the general subject and the special history of each important discipline and specialty, say of physiology or otology or obstetrics, at the end of the courses. This virtual review of the special subject from the historic angle (by appropriate legends) holds out a distinct advantage over the perfunctory oral lecture, since

what is taken in at one ear usually goes out by the other, while whatever rivets the attention or stirs the imagination by the visualizing process is apt to stick in the mind somewhere and be retained. Such a movie, moreover, can be manipulated by the janitor, if need be, as a lecture that delivers itself. To prepare an effective scheme of visualization with legends, so that the essential facts in a course, say on physiology of the circulation or diseases of the nervous system, shall be reviewed and fixed in the mind by the historic milestones, implies *expertise* and might be a fascinating task for an expert or group of experts. Another matter which can be brought to the attention of students is the advantage of maintaining an interest in the subject through some particular hobby, such as collecting medical classics, incunabula, engravings, caricatures, medals, postage stamps, book-plates, autographs, manuscripts, autograph letters, portraits and personal mementoes of great physicians, specimens of primitive plastic anatomy and pathology, medical amulets, talismans, scarabs, and apotropaic tokens, *ex voto* offerings, primitive remedies and other cultural illustrations of the history of medicine. The Pagel, Payne, Streeter and Osler collections are salient examples of what can be done in the way of book collecting, yet even more might be accomplished, with particular reference to the less expensive but no less valuable pamphlet classics and reprints of important papers, if one begins early. Many such items will be quite within the financial means of students who have the enterprise and the patience to rummage in antiquarian bookstores in the spirit of Goethe's dictum, that the purchasable paintings of to-day, if real values, will acquire, in due time, the prohibitive prices attaching to old masters. Medical numismatics and philately, in particular, are attractive and nowise expensive lines for students, and of considerable heuristic moment. A good instance of the teaching value of medical medals is afforded in the placque recently struck off in honor of Professor Jeanselme, the present occupant of the chair of medical history in the Paris Medical Faculty. The obverse of this medal shows

the old Hôpital St. Louis, with the legend *Laborantibus vel ex cute vel lue vel lepra Nosocomium;* in other words, syphilis, of old time, was frequently confused with leprosy, psoriasis or other cutaneous eruptions and hence not recognized as an individual disease, even when yielding to mercurials, which is the key to the puzzling problem of its early history. The obverse of the medal of the Royal College of Surgeons shows Galen studying the robber's skeleton by the mountain-side—one of his few real contacts with human anatomy. The German nautical medals of the World War period are all featured by well-executed skeletons, as symbols of Death. The medical medals of the Paris Mint (*La Monnaie de Paris*) are the work of the most talented numismatic artists of France and can still be had at very reasonable prices. Replicas of Greek coins, illustrating the beginnings of descriptive biology (animals and plants) and the ancient medical shrines, are manufactured at the British Museum, and reproductions of Pompeian and other ancient surgical instruments at Magdeburg. Beautiful plaster of Paris reproductions of antique votive tablets, statues and busts of Im-hotep and Æsculapius, and bas-reliefs illustrating the Æsculapian cult (*Heros Iatros*) are obtainable from the Gyps-Fabrik of the Berlin Museum, and Maltese specimens of palæolithic anatomy from the Hon. T. Zammit, The Museum Vallita, Malta. Students sojourning in Mexico, Central and South America, Africa, Oceania or the far East may have opportunities to pick up specimens of primitive amulets, apotropaic objects, primitive plastic anatomy or of pathological delineation by natives *sans le savoir*. It may not be long before such objects become scarce and difficult to obtain, even as national costumes are disappearing in Spain and other parts of Europe or as natives of Tahiti or Luzon are adopting the *traje blanco*. The "convulsion-clock" of Moravia, which was wound up with the idea that an infantile spasm would terminate as it ran down, is in fact, no longer obtainable. The handsome hard-wood book-stands carved by Igorots around Baguio (Philippines), illustrating their skill in delineating ethnic (constitu-

tional) anatomy, have gone up in price. This is also the case with the scapulary-amulets and *ex-voto* objects of Central Europe, of which Elizabeth Villiers made such a remarkable collection. No doubt such things might be manufactured wholesale by machinery, like the porcelain netsukés of recent Japan, were there any great demand for them in commerce, but they would never have the authentic interest attaching to the *bonafide* hand-made article.

When the students have become fairly familiar with the names of the great leaders of medicine, what they stood and stand for, it is advantageous to give a library demonstration of the basic texts and medical classics associated with these names, similar to those inaugurated by Billings at the Johns Hopkins Hospital in 1889-90 or by Finlayson at Glasgow. Here, the Catalogue of Historical Texts in the Surgeon General's Library (*Index Catalogue,* 1912, 2. series, xvii, 89-178), or the Syllabus and Specimen Extracts prepared for his classes by Professor John C. Comrie (University of Edinburgh) will be of immediate help. While it is expecting too much that the lines of approach indicated above should, all of them, be tried in a given year or semester, or even in the entire period from matriculation to graduation, yet, by dint of a little perseverance and ingenuity, enough can be interpolated here and there to give the student a fair vista of the history of his future profession. The main thing is that it should be made fascinating, stimulating, inspiring, the reverse of boresome or burdensome, and this will depend upon the personality and mentality of the professor or instructor delegated to carry on such work. It goes without saying that he should be, not a "dead one," a "fossil," a "stuffed shirt" or a "flat tire" but a "live wire," a teacher of the active, going, Osler type, informed with that just perception of the needs and temperamental handicaps of youth which is possessed or acquired only by true men of the world. Osler, Hare tells us, "went into the post-mortem room with the joyous demeanour of the youthful Sophocles leading the chorus of victory after the battle of Salamis." The essential thing is adherence to the simple Osler

plan: Bence-Jones urine, say you? who was Bence Jones? Percussion; who originated it? Did he describe it as an invention or a discovery? How does an invention differ from a discovery? Who first discovered and described pectoriloquy? the succussion sound? ægophony? Cheyne-Stokes respiration? Who invented the stethoscope? Who were his contemporaries? What important American physicians were trained in Paris at this time? Why was Paris the great center of surgical teaching in the 18th century and of internal medicine in the Napoleonic period? Questions such as these, leading from one gain in knowledge to another by easy steps, are obviously the very best way of reviewing the essentials of any branch of medicine and can be made to hold the attention of students if the personality of the teacher is engaging and stimulating; and then, too, they may haply be the initiation of some students in the difficult art of using their own minds, of thinking for themselves, of dealing with ideas *quâ* ideas. That, at any rate, was the essence and aim of Osler's teaching in his Baltimore period. At this point, an utterance of William Warner Bishop, the able librarian at Ann Arbor, is still apposite and worth quoting:

> "Without a sense of the historic setting of his work a man is almost as hopeless as is the man who lacks a sense of humor! You cannot argue with the one or the other. In fact, I dare go further and affirm that only by the combination of the historical and the experimental methods can any work of first rate importance be produced in any field of knowledge."

A fortiori, the historical review is the very best mordant to fix the basic facts and principles of the different medical disciplines and specialties in the minds of students. While this is not necessarily the case in teaching mathematics or mineralogy or navigation, a sufficiency of experience goes to show that, with some medical students, the historic data, if early engagingly presented, do "make incision in the memory." For most students, there is still truth in the old German proverb: *Was Hänschen nicht lernt, lernt Hans nimmermehr.* At the Baltimore Institute, the main line of endeavor will, of course, be post-graduate instruction in methods and lines of advanced research work, and here,

apart from such teaching as that of Pagel in Berlin, Sudhoff in Leipzig, Singer in London or Miller in Milwaukee, "the echoes have been many and the voices few." [5] In other words, apt pupils are as difficult to find as efficient teachers, and there has been little or no organization of preliminary studies incident to advanced work. Palæography, for instance, the approach to a crabbed undecipherable, papyrus or manuscript, whether in cursive uncial, majuscule or minuscule Greek or contracted Ducange Latinity, the script of later centuries, or what is now pondered by court-room experts in chirography, is as definite and orderly a procedure as the conduct of a physical experiment or the steps in analyzing an unknown chemical substance. It is taught at the *Ecole nationale deschartes* (Paris), in a course of three and one-half years, restricted (it is said) to 20 pupils, and with a degree and diploma of *Archiviste paleographe.* Instruction is also given in the larger European Universities. An outstanding exponent within our profession is Wickersheimer, who has catalogued the MSS. of the Library of the University of Strassburg. The pathway into the study of medical manuscripts is, of course, the study of the early printed books. The science of the medical incunabula was initiated by Sudhoff and the first exhaustive study of the entire known material, by and large, will be that undertaken by Klebs and himself. Introductory studies of the German medical incunabula by Sudhoff (1908) and of the 15th century pest-tracts by Klebs and Sudhoff (1927) have already been printed. The pathway into the medical incunabula is the study of the medical classics of classical antiquity and Byzantium, with an eye on the Islamic literature, the Du Cange *Glossarium mediae et infimae latinitatis* (Paris, 7 v, 1840-50; *Glossaire françois,* 2 v. Niort, 1878-9) and the catalogues of incunabula. A *Primer of Mediaeval Latin* (a good anthology) by Charles H. Beeson was published in 1925. Apart from such main lines as these, there is immense amount of work to be done in the mere testing, correcting and ultimate

[5] Goethe.

ascertainment of innumerable dates and data in the general history of medicine, particularly American medicine. The individual medical histories of a number of the Western States are now in process of intensive study by investigation of the records of the State Historical Societies. The recent study of Knight and Zeuch on the old 17th Century portage areas, over which Fort Dearborn (ultimately Chicago) was built, with Zeuch's own subsequent *History of Medical Practice in Illinois* (v. 1, Chicago, 1927) are cases in point. As far as the history of American medicine is concerned, this is the most important departure of recent years. Much remains to be done for the Eastern, Southern and far Western States. The best lines of planning and execution will probably be learned from those prairie and Northwestern States which have recently acquired an historic background. This phase, as being archival, is necessarily dry and, in the main, of local interest only; but upon such records are based such excellent narrative records of the total subject as those of Mumford and Packard (now in process of revision). The main sources have been the earlier investigations of Thacher, Gross, Billings, Toner, and for individual states and cities, those of Massachusetts (Green, Burrage, Harrington, Farlow), Maryland (Cordell), New Jersey (Wickes), Ohio (Juettner, Handerson), Indiana (Kemper), Iowa (Fairchild), New York (J. J. Walsh), Missouri (Goodwin, Outten, H. W. Loeb), Kentucky (Drake, Gross, McCormack), California (Bard), Nebraska (von Mansfelde, Cutter), District of Columbia (D. S. Lamb), Philadelphia (Henry, Ruschenberger, Norris), Chicago (Hyde, Weaver) and Milwaukee (L. F. Frank). The more picturesque data, such as the Winthrop journals and inoculation protocols of Massachusetts, have long since been exploited. The *afficionado* of advanced research work on the American terrain is, in fact, not unlike the literary aspirant in *Life,* who after studying everything from printers' marks to rhetoric, from Beowulf to Browning, from Gilgamesh to Joyce's *Ulysses*, settles down in a hall bedroom, pen in hand, against the conundrum: "What the

hell shall I write about?" But, eliminating the dubious prospects of coin and *kudos,* all this is illusory. The success of Sudhoff's teaching was largely due to the simple proposition that the definite settlement of any fact or date is of infinitely greater consequence than sensational writing, florid eulogy or dull repetitions on Hippocrates, Paré or Sydenham. It takes much more time, labor and trouble to get facts, dates and references accurately recorded than to write the book containing them and, as stated, an immense amount of work remains to be done in the definitive settlement of basic data. There could be no better national repository and public *Archiv* for such records than the Baltimore foundation.

At the close of his address, Dr. Welch stressed the humanistic aspect of medical history, in other words, the humane side of medicine, as the most important of all. The power of medicine as a civilizing medium is, in fact, only just coming to be realized. A fair index of the stream of tendency is afforded in President Lowell's dictum that in the 17th century, a conquering nation strove to change its neighbors' religion, in the 18th their commercial relations, in the 19th their laws and in the 20th their drainage. The sanitary improvements effected by the U. S. Army in Cuba, Porto Rico, Panama and the Philippines are good cases in point. American policy in the Philippines, in particular, is one of the most significant, expensive and altruistic experiments in social welfare yet attempted. The enlarged concept of social medicine, as a main coefficient in social welfare, was one of the principal outcomes of the World War. Its main lessons were acquired from the team-work and group-methods necessary to the administration of military medicine and sanitation on a grand scale, and from this *aller droit au but* derives, perhaps, the aggressive stand taken by some of its protagonists. Yet, even a decade before the close of the European War, Kipling had already stressed the growing importance of the doctor in a newer world of "many inventions," sudden, unforeseen emergencies and "change become inevitable":

"There are only two classes of mankind in the world—doctors and patients. Every sane human being is agreed that this long-drawn fight for time that we call life is one of the most important things in the world. It follows, therefore, that you, who control and oversee this fight, and who will reënforce it, must be among the most important people in the world, . . . In all times of flood, fire, famine, plague, pestilence, battle, murder and sudden death, it will be required of you that you report for duty at once, that you go on duty at once, and that you stay on duty until your strength fails you, or your conscience relieves you, whichever may be the longer period. . . . Have you heard of any legislation to limit your output? Have you heard of any bill for an eight-hour day for doctors? Do you know of any change in public opinion which will allow you not to attend a patient when you know that the man never intends to pay you? Have you heard any outcry against those people who can really afford surgical appliances and yet cadge around the hospitals for free advice, a cork leg or a glass eye? I am afraid you have not. It seems to be required that you must save others. It is nowhere laid down that you must save yourselves. That is to say, you belong to the privileged classes. . . . You and kings are about the only people whose explanation the police will accept if you exceed the legal limit in your car. On presentation of your visiting card, you can pass through the most turbulent crowd unmolested and even with applause. If you fly a yellow flag over a centre of population you can turn it into a desert. If you choose to fly a Red Cross flag over a desert you can turn it into a center of population toward which, as I have seen, men will crawl on hands and knees. You can forbid any ship to enter any port in the world. If you think it necessary to the success of an operation in which you are interested, you can stop a 20,000 ton liner with mails in mid-ocean till the operation is concluded. You can tie up the traffic of a port without notice given. You can order whole quarters of a city to be pulled down or burnt up, and, you can count on the warm coöperation of the nearest troops to see that your prescriptions are properly carried out. . . . You have been and always will be exposed to the contempt of the gifted amateur—the gentleman who knows by intuition everything that it has taken you years to learn. You have been exposed, you always will be exposed to the attacks of those persons who consider their undisciplined emotions more important than the world's most bitter agonies—the people who would limit and cripple and hamper research because they fear research may be accompanied by a little pain and suffering. But you have heard this afternoon a little of the history of your profession. . . . You remain now, perhaps, the only class that dares to tell the world that we can get no more out of a machine than we put into it; that if the fathers have eaten forbidden fruit, the children's teeth are liable to be afflicted.[6] Your training shows you that things are what they are and the consequences will be what they will be, and that we

[6] An amateur might regard this Biblical allusion as a foreboding of Hutchinson's teeth, but, as Jacobi used to say, "it remains for him to prove it."

deceive no one but ourselves when we pretend otherwise. . . . At a time when few things are called by their right names—when it is against the spirit of the times even to hint that an act may entail consequences—you are going to join a profession in which you will be paid for telling men the truth and that every departure you may make from the truth you will make as a concession to man's bodily weakness and not mental weakness."

Much water has flown under the bridges since this pronouncement, which now sounds a bit late-Victorian. With the close of the World War, the family doctor's progress became recessional; venery, as distinguished from venereal diseases, came to be a matter of universal discussion and fanciful portraits of the greater leaders of medicine have been used to advertise drugs and surgical appliances. The total failure of the late Dr. Meltzer's Medical Brotherhood for the Furtherance of International Morality goes to show, moreover, that medicine is to date as far from being an efficient agency for promoting international peace as the law itself. Intensive study of the history of medicine is intended for doctors alone, just as the history of hygiene and sanitation, when it comes to be written, will have a definite appeal to the general public. Such studies, if carefully differentiated and kept apart, will always tend to diminish our pride, in the realization of the thousand-fold labors and vast stretches of time required to lift the doctor to his present social status and bedside medicine to its now commendable estate.

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THE COMMON AFFECTIONS OF THE COLON, THEIR ORIGIN AND THEIR MANAGEMENT

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A review of 2500 case histories of private patients with digestive troubles living in and around New York City shows approximately the following distribution of the more common affections of the colon:

Constipation	500 cases per thousand
Common anomalies (redundant colon, low cecum)	
of each	200 cases per thousand
Colonic irritability ("simple colitis" including "mucous colitis" and diverticulosis)	200 cases per thousand

Next in order are:

Colitis gravis (including "ulcerative colitis")	9 cases per thousand
Carcinoma	6 cases per thousand

In other parts of the world or in other types of practice, one would encounter the specific dysenteries in varying degrees of frequency, viz.:

Bacillary dysenteries, epidemic and endemic

Protozoal dysenteries, amebic and flagellate, as well as the chronic non-dysenteric forms of protozoal infestation, and

Tuberculosis.

Until quite recently, the terms constipation and diarrhea were employed to cover almost the whole range of disturbed colonic physiology. No condition was regarded as worthy of serious consideration unless dignified by the presence of an advanced organic lesion. Nowadays, the ever increasing clinical application of the Roentgen method of study has changed all this, and one can follow almost a whole gamut of functional alterations from early irritability to complete colonic decompensation.

ORIGIN AND FREQUENCY OF THE COMMON AFFECTIONS OF THE COLON

The common affections develop as a result either of a congenital anomaly of the colon or of an instability of its autonomic control or from an interplay of both factors. When it is realized that perhaps one-fifth of all patients

harbor a colonic anomaly of some clinical significance, and that a much greater number, if not an actual majority, suffer from instability of the involuntary nervous system, it should not be so surprising that colon complaints are among the most common encountered in practice.

Another reason for this frequency is that the evacuating function of the bowel is under voluntary as well as autonomic control. This opens up the possibility of abuse through vicious habit formation. Bad habits vary from sheer carelessness and neglect in moving the bowels to the most bizarre types of meddlesome interference culminating in the present craze for irrigations. Similarly, the effects on the bowel vary from simple rectal impactions to attacks of acute hemorrhagic colitis. It is extremely doubtful whether there is another system of the body—cardiac, respiratory, urinary, nervous, or what you will—that is so susceptible to damage by improper methods of living and unsound attempts at treatment. Fortunately for all of us, the colon possesses a remarkably high degree of tolerance and a surprising power of recuperation, once it is liberated from injudicious interference.

Owing to lack of space, we shall limit this presentation to a discussion of the first three conditions listed as most common at the beginning of this paper.

Constipation

Constipation may be roughly defined as an impairment in the inherent capacity of the colon to produce formed stools at regular and frequent intervals.

Etiology.—The etiology of constipation is often complex, and may be due to one or more of the following causes:

1. Congenital anomaly.
2. Body habitus.
3. Diet.
4. Psychic and nervous factors.
5. Vicious habit formation.

1. *Congenital anomaly.*—The most important congenital anomaly causing the production of constipation is redundancy of the colon. Over three-quarters of the patients with this malformation suffer from intestinal stasis, often of great severity. One should not imagine that the redundant loops cause actual obstruction, but rather that they furnish the site for the development of localized spasms. A fuller consideration of the redundant colon will be presented in a later section.

2. *Body Habitus.*—There is no longer any question that body habitus exerts a definite influence on gastro-intestinal motility. For example, in sthenic (stocky) individuals, the bowels normally tend to be free, moving spontaneously as often as three times daily. On the other hand, in asthenic (slim) persons, the bowels normally move but once a day, or perhaps less often. This is not to say that visceroptosis is invariably associated with constipation, or that constipation in asthenics can only be relieved by correcting the ptosis, or even that correction of the ptosis alone is invariably followed by relief of the constipation. The fact remains however, that constipation is more common in the asthenic type than in the sthenic; and that abdominal support is always beneficial in ptotic constipated patients.

3. *Diet.*—Irregular eating habits are a common cause of constipation. "No regular stool output without regular food intake" is a safe rule for patients.

A common dietetic error is the consumption of a highly concentrated dry diet. With the exception of an occasional dish of soup or cup of coffee, many persons consume practically no fluids (especially during the winter) from one day's end to another. In such cases, the drinking of water on a fasting stomach in the morning as well as before meals, may be all that is necessary to cure the constipation.

Simple starvation or inordinate food restriction is also a common cause of constipation. In some cases, there is

an actual physical cause preventing the consumption of normal amounts of food, such as an obstruction in the digestive pathway, or a painful lesion which causes fear of eating. In many individuals, however, various articles of diet are progressively eliminated in an awkward attempt to cure the very constipation that is aggravated by the process. Obviously, the remedy for this state of affairs is the early restoration of an enlarged and balanced dietary.

It is a matter of common knowledge that certain individuals habitually omit from their diet those foodstuffs possessing inherent qualities of increasing intestinal peristalsis. Such foods include the vegetables and cereals with cellulose residues which stimulate peristalsis chiefly by mechanical means; the fruits which also act mechanically, as well as by the presence of cathartic sugars, acids and salts; the sugars themselves; and the fats which act both chemically and mechanically.

For some reason that I have never been able to understand, milk is commonly believed to be constipating. In my experience, raw sweet milk seems to have rather a beneficial laxative effect in some mild cases of spastic constipation. It is to be recommended in malnutrition even if associated with constipation, but must be avoided in all forms of frank colitis.

4. *Psychic and Nervous Factors.*—The importance of psychic factors in constipation can hardly be exaggerated. Ever so many people know from experience that they cannot possibly have a bowel movement when nervous or worried, or while actively engaged in the ardent pursuit of their daily occupation. Even mild excitation, such as that associated with travel and change of environment, is a potent cause of constipation in susceptible individuals, as are, of course, the grosser emotions of fright and anxiety.

One of the peculiar facts in connection with constipation is the concern with which some individuals regard their

failure to secure a daily bowel movement. Not only may an occasional omission be perfectly explicable on the basis of some of the causes just mentioned, but it may even be regarded as well within normal limits if it is not associated with physical discomfort or disability. Unfortunately, these apprehensive individuals only too often develop either a vicious bowel habit or an apprehension neurosis or both conditions.

Fatigue may also be considered under the head of nervous factors. A sufficient degree of general bodily rest and relaxation is essential to the proper functioning of all the organs; and the bowels form no exception to the rule. Whether or not the fatigue products of metabolism are actually constipating, it is nevertheless certain that many cases of costiveness are associated with insufficient rest, and particularly with insufficient sleep. This is very often the case with those who work at night.

5. *Vicious Habit Formation.*—Perhaps the greatest perpetuating cause of constipation is vicious habit formation. Much of the trouble is due to early neglect of the bowels. Getting up too late before rushing to school, shop, or office, and later neglecting the call of nature because of preoccupation, laziness, or embarrassment, have frequently been pointed out in this connection. To this should be added the uninviting condition of toilets in the poorer types of schools, shops, farms, and tenements—conditions that demand remedy at the hands of the appropriate social, educational, or administrative authorities.

Once the chain of regular bowel evacuations is broken, once the fecal stasis begins to cause discomfort, it is but a short step for the sufferer to seek artificial methods of relief. He embraces thenceforth either the cathartic or enema habit or both, and his constipation bids fair to remain fixed for life. Physicians, too, have not been without blame in this matter. A prescription for a cathartic, no matter how well fitted to the temporary needs of a patient, may become just as persistently used as any patent medication.

Varieties of Constipation

Although it is necessary to distinguish several different forms of constipation, it should be stressed that pure forms are rare, and that spasm is a common factor in practically every variety of constipation. The following types may be distinguished for purposes of discussion:

1. *Atonic Constipation.*—This is the variety commonly found in asthenic and malnourished individuals. A congenital intestinal atony or hypoplasia is sometimes assumed to exist in these cases. Atonic constipation may also occur as an end result of long-continued abuse of

Figure 1

cathartics and enemas. It may be limited to the proximal colon, particularly in cases of marked spasm of the distal large intestine. (Figs. 1 and 2.)

FIGURE 2

2. *Spastic Constipation.*—This, perhaps the most common variety of the disease, is often associated with the other forms, as was just mentioned. The distal part of the gut is the portion usually involved by the increased tonus, the condition affecting either the entire colon from the hepatic flexure onward, or certain special areas such as the descending colon, the pelvic colon, or the anal sphincter alone. In the last named instance, local lesions may play

an exciting rôle (fissures, ulcers, and hemorrhoids). When spastic constipation is associated with atony of the proximal large intestine, the cecum, ascending colon and transverse colon act as reservoirs for large accumulations of feces which are passed, small portions at a time, beyond the contracted areas. Clinically, this condition may be associated with daily, but quite insufficient evacuations.

The common symptoms of spastic constipation are abdominal cramps, generally localized in the left lower quadrant, often increased by defecation, and still more by catharsis; peristaltic unrest; and the passage of small stools, hard and lumpy in character (marble or sheep-dung stools). Examination of the left lower quadrant often reveals a tight cord corresponding to the iliac colon. The ceco-colon is often distended, gurgling and tender. The anus may feel tight to the examining finger, while inspection of the pelvic colon with the sigmoidoscope often reveals the presence of an irritable condition which may prevent the introduction of the whole length of the instrument.

3. *Dyschezia.*—In some cases of constipation, it is found that the rectum is practically always filled with feces. Study by means of the Roentgen ray shows that there is no delay in the progress of the stool through the proximal colon. In other words, we are dealing with a condition in which that portion of the gut charged with the actual act of defecation fails to function. The pathogenesis of this disorder, known as dyschezia, has been described by Hurst as follows: "The habitual neglect of the call to defecation leads to the accumulation of the feces in the rectum and pelvic colon which gradually become more and more distended. The distention diminishes the tone and impairs the contractility of the musculature; as the force required to empty the rectum when over-distended with feces is much greater than that required to empty it under normal conditions, the weakened muscular coat is incompetent to do its work, and, even if a greater effort be made, the evacuation remains incomplete. In time, the muscu-

lature of the pelvic colon and rectum may become so profoundly atonic and paretic that it can never be restored to its normal condition." Dyschezia may also develop secondarily to any condition which causes pain during defecation, such as inflamed or thrombosed hemorrhoids, anal ulcers or fissures, and pelvic peritonitis. In women, the condition is frequently caused or aggravated by childbirth.

4. *Constipation with Redundant Colon.*—This will be discussed in the section on the redundant colon.

5. *Constipation with Mucous Colitis.*—This will be discussed in the section on the irritable colon.

Diagnosis of Constipation

The diagnosis of constipation may be made from the history, the physical examination, stool inspection, and Roentgen examination.

The history is usually straightforward. The patient complains that he has less than one stool daily, or that the feces are hard and the total output small. Occasionally, however, the story is misleading in that, despite a daily movement, the actual output may still be insufficient to empty the colon adequately, according to the best objective standards. Such cases may be designated "masked constipation."

Physical examination is performed by abdominal palpation and by rectal touch. By the former method, a contracted or knotted and usually tender iliac colon may be rolled over the left iliac fossa in cases of spastic constipation. In dyschezia, a rectum filled with hard scyballa may be discovered by the gloved finger. If the sphincter ani is very painful, the rectal packing may be determined in women by vaginal investigation.

Stool inspection reveals at once any departure from a normal bowel movement. Unfortunately, the criteria of a normal bowel movement do not appear to be as well

known as they should be. The amount of stool evacuated daily should represent a fecal column reaching from about the mid-descending colon to the rectum. This column is generally broken up into segments of the size and consistency of frankfurter sausages. A stool of normal formation contains about 75 per cent water. There is no mucus, blood, or pus. In constipation, the amount of feces expelled daily is small, the form is lumpy, the consistency hard. Fresh blood is occasionally present from bleeding fissures or piles. Mucus may also be noted.

Roentgen examination gives the most comprehensive evidence as to the presence of constipation, and the existing variety. The ideal procedure is to administer an opaque meal and see what happens to it. No cathartics or enemas should be permitted during the course of the examination unless a rectal impaction appears imminent. Observations should be made daily with the X-rays until the barium is completely and spontaneously evacuated from the rectum. Under normal conditions, the colon is empty at 48 hours, or between that observation and the next at 72 hours. In order to complete the study by observing the exact course and extent of the colon, an opaque enema is administered.

Treatment of Constipation

Owing to lack of space, only the chief principles of therapy will be presented in schematic form as follows:

1. Prophylaxis should provide for regular food intake, for routine visits to the toilet, sufficient water drinking, especially on arising, and a balanced dietary containing sufficient roughage.

2. Visceroptosis and malnutrition should receive appropriate attention. Abdominal support and a fattening diet are indicated. For the latter, butter and olive oil are particularly to be recommended.

3. The psychic and nervous causes of constipation should be controlled as much as possible by appropriate

mental and emotional hygiene, by adequate vacations, rest, and sufficient sleep, and by sedative medication. Small doses of chloral and bromide may be effectively prescribed over long periods of time.

4. Vicious bowel habits should be broken up by the immediate and complete withdrawal of cathartics and enemas. The period of waiting for the resumption of spontaneous bowel movements is often a most trying one for physician and patient. It is always best to combine the withdrawal treatment with a Roentgen study, especially for psychological reasons.

5. Atonic constipation should be treated by careful, not abrupt stimulation, with gradually increasing amounts of roughage added to a basically smooth diet. Agar and psyllium seeds are of value.

6. Spastic constipation should be treated by rest, sedatives, lubricants, and antispasmodics. The oils may be administered by mouth or by rectum. For rectal use, a small hand syringe works admirably. In cases of spasm limited to the lowermost colon, a course of local applications of magnesium sulfate through the proctoscope, as advocated by Soper, is beneficial.

7. Dyschezia should be treated by local measures directed systematically to the rectum. Local lesions should receive appropriate attention. Otherwise, small water injections, retention oil enemas, or suppositories are indicated. In some cases, a course of rectal dilatations, as with Wales bougies, may be helpful.

8. Cathartics have no place in the routine treatment of constipation. Being habit forming drugs, they increase the evil instead of relieving it. Their use should be reserved to special occasions where purgation is deemed advisable, as well as to the care of the very aged and of those suffering from certain chronic diseases. Cathartics may also be of use temporarily, in the case of patients who are bed-ridden from any cause. The mildest drug

in the smallest effective dose is the rule for all such medication.

9. Irrigations likewise do not cure constipation. If they are deemed of value for some ulterior purpose, it must be borne in mind that they accomplish their end at the expense of normal colon function.

Common Anomalies of the Colon

Clinical Significance of Anomalies.—Anomalies of the colon are a distinctive expression of organic constitutional inferiority of the digestive tract. They are of importance clinically because they are frequently encountered, and because they represent points of weakness in the large intestine which predispose their bearers to colonic malfunction. Congenital anomalies may cause symptoms in all their owners some of the time, in some of their owners all of the time, but are under no obligation to cause symptoms in all of their owners all of the time. In other words, although the colonic malformation may not become manifest under ordinary favorable conditions of existence, it does attract attention as soon as the subject is exposed to physical or emotional strain, to wasting disease, or to trauma such as surgical operation or childbirth. In general, the tendency is for the organism as a whole to compensate for the presence of a congenital deformity; and it is only when this mechanism breaks down that symptoms arise. This explains the late onset of complaints in many cases. The most common exciting causes of bowel decompensation have just been mentioned. Underlying contributing causes are improper diet, bad hygiene, and viscious bowel habit formation.

The Redundant Colon

The most common congenital anomaly of the large intestine is the redundant colon. It was encountered in almost 19 per cent of a series of over a thousand patients (1927 figures). The redundant colon occurs more often in men and in the sthenic habitus. It is, as the name implies, a condition of congenitally increased colonic length. The

redundancy may take the form of simple pleats or reduplications or of extensive loops and twists. A simpler form is that of kink or angulation. The most frequent site is the pelvic colon. The condition may be familial or hereditary. (Figs. 3 and 4.)

FIGURE 3

Symptoms.—The symptoms associated with redundant colon are constipation, pain, and gas distress. The acute discomforts are generally ascribed to the development of spasm from irritation at the site of the redundancy. In this connection, one should be careful to avoid thinking of a kink or loop as a fixed or static barrier, such as volvulus or stricture. It is true that a loop may become

partially twisted by overloading with gas or feces, but the resulting symptoms of relative obstruction persist only as long as the original factors obtain; and those are usually transient. In other words, we are dealing with neither an organic nor a functional condition, pure and simple,

FIGURE 4

but rather with a combination of both that seems to be characteristic of congenital malformations of the digestive tract in general.

The constipation of colonic redundancy often dates back to childhood. The interval between spontaneous bowel movements may extend from three days to a week or more.

There is often discomfort in the lower right quadrant, characterized as dull, dragging, or sticking in nature, and increased by bodily exertion. Not infrequently there is gas pressure, fullness or pain referred to the exact location of the redundant loop in the left colon. Sometimes precordial distress or increased belching is provoked by gas accumulation under the left diaphragm. The passage of flatus is at times difficult, but when it does take place, is often followed by complete relief of symptoms.

Diagnosis.—The diagnosis of colonic redundancy by physical examination of the abdomen is practically impossible. Similarly, rectal palpation reveals no fecal accumulation, for the delay is invariably above the pelvi-rectal flexure. It is only by careful Roentgen study, both by barium meal and by opaque enema that the existence and the extent of the anomaly can be accurately determined. The enema reveals the exact site and form of the redundancy; the opaque meal shows what it does to give the patient symptoms.

Treatment.—The first step in the treatment of redundant colon (after an accurate estimate of the situation by the methods just mentioned) is the restoration of colonic function. This is all the more important because patients often suffer more from their own ill-advised interference than they do from the underlying condition. The withdrawal of irritating cathartics should be immediate and complete. They serve only to increase the colonic irritability and decompensation. As a matter of fact, enemata may be quite ineffectual in this condition, either because they fail to reach the affected bowel segment, or because, once administered, they become more or less completely "lost" in the long, tortuous, and atonic colon. In some of my cases, 80 to 90 ounces were required to reach the cecum, the normal colonic capacity being 38 ounces. Violent purges are actually dangerous, as, in my opinion, they may produce volvulus, a condition that can only occur in a redundant colon.

Once artificial aids to bowel movement are eliminated—and this may involve considerable tact as well as firmness in the case of some individuals—it is only a question of a few days before the colon builds up enough reserve to begin producing spontaneous stools. These movements, small at first, tend steadily to gain in bulk as time goes on. The further management of the condition does not differ essentially from the general treatment of constipation as already outlined. On the whole, the therapy may be described as conservative and protective. A bulky but not too rough diet is best suited to stimulate effective peristalsis, and forced water drinking is generally necessary to prevent undue drying of the feces.

Lubrication from above and below is very often required, and helps particularly to overcome the associated colonic spasms. It is generally necessary to continue this form of treatment for a long period of time. The patient's co-operation in keeping a careful "stool record" is a real contribution toward a successful outcome. Belladonna in increasing doses is useful when the spastic tendency is excessive.

Although it is not absolutely essential for the bowels to move daily, and a total of 5 or 6 stools a week may be compatible with a very fair degree of comfort, it is well to be on the lookout for gradually accumulating fecal retentions. To overcome these, an occasional thorough but non-irritating colonic irrigation, or else a single dose (1½ ounces) of castor oil may be all that is needed. Only if the above measures fail is a compromise with the cathartic habit justifiable. None but the mildest laxatives should be selected, such as cascara or phenolphthalein; and these should be given, as always, in the smallest dose compatible with satisfactory action.

Surgical intervention is to be reserved for cases of volvulus only.

The Low Cecum

Almost as common as the redundant colon is the anomaly known as the low cecum. It occurred in almost 18

per cent (revised figures) of my cases. This condition is the result of over- or hyper-descent of the cecum during the intra-uterine development of the colon. Normally, the cecum is unattached, whereas the ascending colon is fixed to the posterior abdominal wall. When the ascending colon is provided with a mesentery, the mobility of the cecum is correspondingly magnified. The resulting condition has been described as "cecum mobile." On the other hand, when the normal fixation of the ascending colon is continued downward, the cecum becomes fixed in its turn to the posterior abdominal wall. If, in addition, there is hyperdescent, we may speak of a "low, fixed cecum."

Symptoms—The low cecum occurs most often in women and in individuals of the asthenic habitus. The symptoms associated with this condition are either systemic, being strikingly those of so-called autointoxication—namely, nausea, vomiting, and headache; or else they are local, giving rise to pain or discomfort in the right lower quadrant. As with other congenital anomalies, the symptoms may be absent, the patient being merely predisposed to these special forms of malfunction.

The tendency to vomit is a striking characteristic of patients with low ceca. Such individuals seem to constitute the "easy vomiters" of ordinary experience. Some of them have frequent vomiting bouts from relatively slight causes, such as dietary indiscretion or emotional stress. Others have more severe attacks with sick headaches, so-called bilious attacks. In women, these occur more often during the menses. Many patients suffer from trainsickness and carsickness. The cause of vomiting and headaches is not quite clear. It may be due to a drag of the entire right colon across some part of the duodenum, causing a temporary block with transient duodenal stasis.

The right-sided abdominal pain occurs in about one-half of the patients with low ceca. It is either dull, dragging in nature and constant in occurrence, or else it comes in attacks of colic, sometimes (though by no means always) associated with vomiting. Although tenderness over the

distended and gurgling cecum is commonly present, rigidity and fever do not enter into the clinical picture. Despite this, the diagnosis of "chronic appendicitis" has been freely made in this condition. Indeed, over one-fifth of my series of patients with low ceca have had an appendectomy without (except in the rarest of cases) experiencing any permanent relief of symptoms.

Diagnosis.—The diagnosis of low cecum is best made by Roentgen observation nine hours after a barium (opaque) meal. An opaque enema is less satisfactory in revealing this condition. (Figs. 5 and 6.)

FIGURE 5

Treatment—The treatment of patients with low cecum should embrace the following items and considerations:

1. Rest—physical, nervous, and mental.

2. Fattening cure with abdominal support to restore normal intra-abdominal pressure and to overcome the asso-

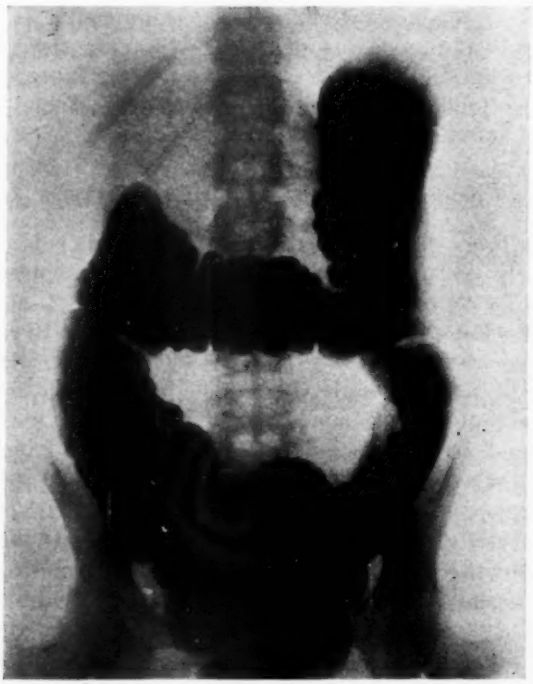

FIGURE 6

ciated ptosis. The position of the cecum, however, is not often altered by medical treatment.

3. Improvement of colon function. The idea is to clear the track ahead and prevent backing up in the proximal colon with resultant increased dragging in that region.

It should be pointed out, however, that gross stasis has not been demonstrated to occur more frequently in low than in normal ceca.

4. Antispasmodics, such as belladonna, and general sedatives, such as repeated small doses of bromid and chloral, or codein.

Surgical therapy.—Removal of the appendix is futile. More radical procedures devised to improve the position of the cecum and to fix it, if movable, though theoretically less objectionable, are perhaps unnecessary, except in rare cases of actual volvulus of the cecum.

Colonic Irritability (Simple Colitis)

Definition.—The syndrome of the "irritable colon" is an extremely useful concept. Broadly speaking, colonic irritability is characterized by instability of function in the absence of a gross colonic lesion. The condition seems often to be congenital in origin. It has also been described under the name "simple colitis," using the term much as one designates the common cold, "rhinitis." This simple functional irritability is to be distinguished from those severe forms of colonic disease, perhaps more properly called "colitis" which are always associated with definite local organic changes resulting from trauma, infection, new growth, intoxication, or parasitic infestation. Finally, it should be borne in mind that an irritable colon may at times develop into a true organic colitis, and that, on the other hand, an organic lesion is practically always accompanied by some degree of irritability.

The pathologic physiology of the irritable colon is somewhat similar to that of the irritable stomach, being characterized by:

1. Hypertonicity, *i. e.*, frequent and irregular spastic phenomena which may co-exist with more or less localized stasis. The term "spastic colitis" is sometimes used to designate this phase of colonic irritability.

2. Hypermotility, as evidenced roentgenologically, and clinically by the passage of mushy and watery stools, generally, though not necessarily with increased frequency.
3. Hypersecretion of mucus. This is generally regarded as a local protective mechanism.

The underlying causes of colonic irritability are, in order of their clinical importance:

1. Instability of the involuntary nervous system, often described as "vagotonia," "spasmophilia," "endocrine imbalance," etc.
2. Constipation and the abuse of cathartics, enemas, and irritating irrigations, particularly.
3. Organic lesions of the colon.
4. Gall-bladder disease.
5. Gastrogenous factors, such as achlorhydria, improper diet.
6. Disturbances of the small intestine, including certain rather ill-defined intestinal dyspepsias; also pancreatic insufficiency.
7. Pericolitis, due to extraintestinal irritation from adhesions, pressure, etc.
8. Remote lesions outside the digestive tract acting reflexly on the colon by way of the involuntary nervous system. Possible examples are "focal infections" in teeth, tonsils, prostate, etc.

Symptoms.—The symptoms of colonic irritability are among the most common encountered in clinical gastroenterology. To begin with, patients suffering from this disorder are frequently aware of their intestinal activities. They have been aptly described as being almost constantly "belly-conscious." Abdominal distress and restlessness, flatulence and distention, gas pains and minor colics, tenesmus, fits of diarrhea with or without preceding constipation, are all familiar manifestations of this condition.

Varieties.—Naturally, there are all degrees and many varieties of colonic irritability. Perhaps the mildest form is that encountered in hypersthenic individuals. Here, a heightened colonic tone is so much the rule that it may be regarded as a condition of normality. Thus, such an individual, even in perfect health, may pass two or three semiformed or even mushy stools daily, usually one after each meal. As time goes on, these patients seem particularly

likely to develop diverticulosis, a condition which is oftimes closely associated with increasing constipation of the spastic variety. It is in these cases, too, that the opaque enema frequently reveals the condition that has been described as "fibrillation." Infection of the diverticula (diverticulitis) may also occur, though this happens relatively seldom in proportion to the total number of cases revealed by Roentgen studies.

Another special and common form of irritable colon is often called mucous colitis (colica mucosa, myxoneurosis coli). This disease is usually associated with a high degree of autonomic instability. In this disorder, mucus is produced in excess; and when inspissation occurs, shreds or casts are expelled, often with painful colics. Patients sometimes mistake these casts for tapeworms. Occasionally, the presence of mucus in the stool is not noticed by the patient; and this symptom can only be elicited by careful questioning on the part of the physician. It is well to remember that mucous colitis is almost always associated with constipation, or at least with incomplete bowel evacuation.

Diagnosis.—On physical examination, the patient usually shows tenderness over the various parts of the colon, and very often over the entire abdomen. Localized tenderness in the right iliac fossa or right hypochondrium is not uncommon, and is very misleading. The diagnosis of "chronic appendicitis" is very often made in simple colitis.

Proctosigmoidoscopic examination is always useful. In the majority of cases, especially when the distal colon is involved, the direct inspection of the mucosa of the rectum and sigmoid clinches the diagnosis. Usually free mucus is seen lying in the gut. The appearance of the mucous membrane depends on the stage of the disease, and on the segment of the colon involved in the pathologic process. The changes are most marked when the distal colon is primarily affected. In early and mild (functional) cases, we find merely congestion of the mucosa. In the more severe and advanced (organic) cases which we are not now

considering, the lesions range from small punctate petechiae and ulcerations to atrophy of the mucous membrane with large or small ulcers, or to the well-known polypoid appearance. Occasionally, spasm is so marked that the introduction and passage of the instrument becomes quite difficult, the patient complaining of an undue amount of pain.

Test meal.—Examination of the gastric contents may prove to be helpful, inasmuch as an achylia or marked hypochlorhydria, when present, is generally related to the associated colitis.

Feces.—The stool examination is of utmost importance. The elaborate laboratory procedures described in the literature, although of value in the hands of specialists, may serve to discourage the more general recourse to this valuable aid in diagnosis. In the overwhelming majority of cases, a mere glance at the stool is sufficient for all practical purposes; yet it is just this simple inspection that is so often neglected. Given a stool which is mushy in appearance, contains an excess of mucus, gives evidence of fermentation by the presence of numerous small gas bubbles on the bottom and sides of the jar, is strongly acid in reaction, has a penetrating sour odor, and the rest of the examination is either superfluous or merely confirmatory. Almost always, gross mucus is present.

The form and consistency of the stool also varies with the part of the colon involved in the pathologic process. The feces may be formed or semi-solid, though in the majority of cases, there is an increase in the water content of the stool. The color depends ordinarily on the food ingested.

The microscopic findings vary in the different types of colitis. There is always an excess of mucus. With deficient gastric or pancreatic digestion, there is always an abundance of meat fibers with or without striations. In fermentative dyspepsia, we often find incompletely digested starch granules or fungi which stain black with

iodin. For more detailed methods of examination, reference may be had to books and articles on this subject. It should be added, however, that the patient should always be placed on a standard intestinal diet (Schmidt) for at least three days preceding the examination of a stool, whenever the findings are at all doubtful.

Roentgen diagnosis.—This is perhaps the most useful single method for the diagnosis of colitis. It will be recalled that the filling and emptying of the colon take place according to a definite time table. Normally, the cecum begins to fill four hours after the standard opaque meal. At six hours, the head of the barium column reaches the region of the hepatic flexure; the tail is still in the ileum. At nine hours, the head reaches the splenic flexure, and the tail has cleared the terminal small intestine. At twenty-four hours, the bowels have moved once; and the left-sided shift has occurred—that is, the barium has cleared the proximal colon in whole or in part, and has become distributed throughout the distal colon. By forty-eight hours, the bowels have moved twice, and the colon is clear except for traces of the barium.

Any departure from the above schedule is abnormal. If the change is in the direction of stasis, a diagnosis of some variety of constipation is in order. When, on the other hand, the colonic transit is hastened, if only in part, there exists a state of irritability which is the essential motor expression of colitis. Colitis may, therefore, be diagnosed, or at least suspected, from the following Roentgen findings:

1. At the "six hour observation," the head of the column is beyond the splenic flexure.

2. At the "nine hour observation," the head of the column is in the pelvic colon or rectum, with or without the passage of a stool containing barium. (Figs 7 and 8.)

3. At the "twenty-four hour observation," the colon is empty.

FIGURE 7

In addition to the abnormalities of function, there are interesting changes in colonic form as revealed by a consideration of the sacculi or haustrations. Normally, these are deep-cutting, evenly spaced, and evenly balanced—that is, the lumen is central, and the haustra on either side are equal in size, and symmetrical. In colitis, there is either irregularity or complete absence of the haustrations, lending an atypical beaded, mottled, or smooth appearance to the fecal column, as the case may be.

Similarly suggestive is a scattered filling of the colon, or actual filling defect, provided, of course, that obstruc-

FIGURE 8

tive new-growth is excluded. Increased gas content of the large intestine is likewise suggestive of colitis.

Prognosis.—The outlook for the absolute cure of colitis is often so uncertain that the prognosis must be guarded. However, it is equally true that some patients can be cured, and many, if not most, can be relieved of their symptoms. In every case, nevertheless, the treatment must be exceedingly painstaking and long-continued, as the underlying autonomic instability is a difficult, if not an impossible matter to eradicate. Many cases still go unrecognized, and are, therefore, either improperly or insufficiently treated.

General Principles of Prophylaxis and Treatment

Before beginning any active interference, a complete and careful survey is indispensable. Perhaps the first step in therapy is the absolute withdrawal of all forms of colonic abuse (cathartics, enemas, irrigations) so frequently indulged in by these patients.

In general, it may be said that the prophylaxis and treatment of colonic irritability are dominated by the neurotic nature of this affliction. Every effort should be made to preserve or restore autonomic stability. To this end, the special hygienic problems of each case must be ascertained, and a sensible program outlined with particular emphasis on work, sleep, rest, and recreation. The emotional life of the patient should be controlled as much as possible, since many attacks of colitis are distinctly associated with psychic trauma. In all cases, rest is important; and complete bed rest may well be prescribed for all debilitated subjects. Exposure to cold and wet is distinctly harmful, and must be avoided. Excess of roughage must be eliminated from the diet, and iced foods and drinks should be used, if at all, with great caution.

Diet.—The dietetic treatment of simple colitis is essentially conservative and protective in nature. The food should be as non-irritating as possible—hence all coarse vegetable fiber must be particularly excluded. On the other hand, to make up for this deficit and to supply enough "frame-work" for the fecal column to ensure adequate peristalsis, relatively large amounts of bland and bulky but wholly nonabsorbable salts have been found most useful. These will be described in detail later.

The bland diet for the irritable colon differs from that for gastric irritation in two particulars. Milk is to be avoided or else reduced to a minimum, as in many cases, it greatly increases gas formation and gas distress. Meat, on the other hand, is generally well tolerated, and may be given from the start in large amounts. A well-balanced diet is secured by a modification of the standard Schmidt

diet, which may be concentrated in regard to the number of feedings to three in the twenty-four hours. All cold foods and drinks are to be avoided. If the above regime should prove too constipating, the best results will be obtained from mineral oil, agar, or psyllium seeds.

As the condition improves, other articles may be added, one by one, to the diet. The stools are to be carefully watched during this process, and if they again become mushy, one must return to the feeding which last gave a normal fecal output, and try some other addition than that which proved harmful. Among the first articles to be added to the basic regime are well-cooked breast of chicken, rice, fish, and finely pureed starchy vegetables. Fermented milks or acidophilus milk are well borne by some patients. The last items to be added—and with the greatest caution—are the raw vegetables and fruits, and, in general, foods containing mechanical or chemical irritants. Indeed such articles may never be tolerated by many individuals.

Medicinal Treatment.—When the stools do not readily resume their normal form and consistency, the administration of an ounce or two of castor oil, repeated weekly if needed, helps to clear out old residues, mucus, and bacteria. In other cases, sodium phosphate or similar salts give better results, since some patients cannot stand even the mild irritating action of the ricinoleic acid. It is important that the salines be given in slightly hypertonic concentration and on an empty stomach, for, when the salts are exhibited in too concentrated form, the excessive osmosis which takes place into the gastro-intestinal lumen may actually cause cramps or even delayed action of the bowels.

The inert bulky chemicals already mentioned are of value in allaying colonic irritability. They not only supply the necessary "roughage," but aid further in mechanically removing mucus and bacteria by "adsorption." The ordinary barium sulfate used for Roentgen diagnosis is admirable for this purpose; so is the bulky diatomaceous earth

known as kaolin. When both drugs are mixed in equal proportions, a thorough suspension is assured. The dose, which is a tablespoonful of each powder twice daily, is best administered in cocoa, fermilac, cereal, applesauce, or some similar thick mixture. This form of therapy should be pushed for long periods, and only gradually discontinued.

Other drugs may be used as occasion demands. The general sedatives (chloral and bromids together in small doses) are always useful to depress autonomic instability. If there is much pain, codein may be ordered, though this is seldom necessary. For overcoming spasm, atropin or belladonna in increasing doses is very helpful, and is probably the best drug for routine use. One may begin with as much as ten or fifteen drops of the tincture three times a day, and raise the dose one drop daily till the symptoms disappear, or the ocular accommodation is paralyzed. When gastric anacidity exists, dilute hydrochloric acid is indicated, the dose being five to twenty drops in a glassful of water to be taken with meals. Conversely, if there is hyperacidity, a neutral antacid such as tribasic magnesium phosphate may be employed when constipation predominates, or the calcium salt when the bowels are loose. The dose of each is one teaspoonful or more, thrice daily.

In many cases, heliotherapy or the artificial actinotherapy seems helpful. The latter is supplied by gradually increasing exposure to the ultraviolet rays. Other patients respond favorably to the application of the abdominal compress. Very probably diathermy is of value in some cases.

Diverticulosis and Diverticulitis

Most cases of diverticulosis are discovered at X-ray examination or at autopsy, and cause no symptoms. Trouble only arises when the contents of the sacs become so inspissated as to cause perforation, or when the sacculi themselves become infected. Both these complications lead to perisigmoiditis in its acute or chronic varieties. The prophylaxis of diverticulitis consists in the treatment of

the underlying spastic constipation, with special attention to adequate lubrication. Mild cases are treated the same as simple colitis, with even more emphasis on the use of barium or barium and kaolin mixture in large doses. These powders fill the saccules with inert matter, thus replacing the harmful putrefactive or infected contents. In recurrent cases, the barium treatment must be continued indefinitely.

In the presence of infection and even of small perforations, a conservative, expectant therapy is justifiable, inasmuch as the escape of distal colon contents is less dangerous to the peritoneum than is that of the more fluid and virulent material present in the large intestine. In the face of these complications, complete bed rest, the application of an ice bag or coil, and the administration of sedatives is often effective. Should, however, the clinical symptoms point to progressive peritoneal involvement or to actual abscess formation, prompt operative relief is, of course, indicated. In all doubtful or borderline cases, a surgeon should be called early in consultation.

Mucous Colitis.—The treatment of mucous colitis involves:

1. Control of the underlying constipation.
2. Control of mucus accumulation.
3. Control of the colic.
4. Improvement of the nervous and general health.

1. The underlying constipation is to be controlled by the measures already outlined. If spasticity is marked, or if the colon is very sensitive to irritants, it is well to avoid the use of rough foods. Indeed, these may be more harmful under such circumstances than mild tonic laxatives, such as cascara, agar or phenolphthalein agar. Otherwise, the general rule is that the diet should be built up as quickly as possible, so that colonic tolerance to the ordinary food irritants should be increased rather than

diminished. In general, the oils are well borne in mucous colitis, both when given by mouth and by rectum. Overnight instillations of warm olive oil, cotton seed or corn oil are particularly beneficial, not only for the constipation, but for the removal of the mucus as well.

2. To overcome the accumulations of mucus, a weekly purge of castor oil or of calomel is recommended. Colon irrigations are occasionally of benefit. At first, the irrigations may be given daily or every other day for one or two weeks; then twice a week for several more weeks; and, finally, once a week until the mucus is eliminated. Before the irrigation proper, a cleansing enema should be given to remove whatever fecal accumulation may be present. Plain hot water, saline solution, or lime water in amounts ranging from twelve to twenty-four quarts may be employed for the irrigation. When spasticity is prominent, local intraintestinal applications of magnesium sulfate are very well worth trying. Transduodenal lavage with a hypertonic saline solution, as recommended by Jutte, may give relief in some cases.

3. The treatment of the attacks of colic necessitates active sedative and relaxing measures. Rest in bed; bromid by mouth; atropin and codein by hypodermic injection; all in full physiologic doses, together with hot applications to the abdomen in the form of hot water bag, electric pad, poultice or stupe, or even a hot bath, are among the most useful measures. In addition, the mucus accumulation must be removed, whether by castor oil by mouth, or by colonic irrigations, or by the administration of oil enemata.

For measures directed toward the improvement of the nervous and general health, the reader is referred elsewhere. Inasmuch as increased fatiguability is a characteristic of patients suffering from mucous colitis, it is essential that they should get plenty of rest and sleep, and that they should avoid strains and excitement of all sorts, mental, physical, and emotional.

Summary

1. The most common disorders of the colon as encountered in private practice are constipation, the common anomalies, and simple colitis.

2. The most important etiologic factors are the presence of congenital malformation, autonomic nervous instability, and vicious habit formation.

3. Roentgen-ray studies give the most comprehensive information as to the presence and extent of these disorders.

4. Congenital anomalies are more common than is generally appreciated. They act as potential points of irritation, but ordinarily produce symptoms only when the compensatory mechanism of the colon is considerably impaired, if not entirely disrupted.

5. The general aim of treatment is the restoration of colonic function. To this end, gentle and conservative measures are most effective. Aggressive interference, such as with irritating cathartics and irrigations, tends only to aggravate colonic malfunction.

Legends

Fig. 1. Normal colon in asthenic individual. Opaque enema. Normal amount required to fill colon is 38 oz. Note the relatively straight course and the "postural tone," the distal colon being normally narrower than the proximal.

Fig. 2. Atonic colon. Opaque enema, 79 oz. required to fill. Note loss of tone throughout distal colon with relative dilatation. Contrast with Fig. 1.

Fig. 3. Redundant colon. Appearance 24 hours after barium meal. Note gas caught in distal loop.

Fig. 4. Redundant colon. Opaque enema. Note double splenic flexure and long straight efferent loop (arrow).

Fig. 5. Low cecum. Appearance 9 hours after barium meal.

Fig. 6. Low cecum. Opaque enema.

Fig. 7. Simple colitis. Appearance 9 hours after barium meal. Note "streaking" through transverse colon and early packing in rectum.

Fig. 8. Simple colitis ("Spastic colitis"). Appearance 9 hours after barium meal. Note increasing spasticity and breaking-up of the fecal column in its rapid passage to the rectum.

HISTORY OF POST-GRADUATE MEDICINE IN NEW YORK CITY

THOMAS JEFFERSON HARRIS

Post-graduate medicine is to-day in New York City no longer an experiment. It is an accomplished fact. While much needs yet to be done to make it possible for every practitioner of medicine easily to keep himself abreast of the times the opportunities are already numerous and increasing constantly. Like most other movements of this kind its beginnings were in obscurity. The history of its inception and growth is an interesting one. The credit for what has been secured is due to a small group of men who following their graduation in medicine during the 60's went abroad and were filled with the vision that they saw in the places they studied, especially in Vienna. Profoundly impressed with the importance of such teaching, they came home fired with the desire to establish it on this side of the water.

In spite of innumerable discouragements they persisted in their purpose and succeeded finally in bringing around the desired results. With one or two exceptions they have all passed to their reward but their names shine bright in the Hall of Fame.

The first undergraduate medical school in this city, the New York College of Physicians and Surgeons, was established in 1769, four years after the founding of the medical school of the University of Pennsylvania.

The distinction of being the first place to give systematized instruction to *graduates* in medicine belongs to New York City. As early as 1809 (1) the New York Hospital recognized the importance of giving practical instruction to medical students and at that time threw open the wards of the hospital to them, appointing members of the Faculty of the College of Physicians and Surgeons as instructors. No distinction appears to have been made between students and graduates in medicine and it is probable that the latter

class availed themselves of the privilege of visiting the wards of the hospital from time to time.

In 1820 the New York Eye Infirmary, later the New York Eye and Ear Infirmary, was founded. In the annual report for the year 1822, it is stated that "the number of pupils who have attended the practice and operations of the Surgeons of the Infirmary has been increased to 28." This shows that teaching in diseases of the eye had been instituted almost simultaneously with the founding of the Infirmary. This instruction as in the case of the New York Hospital was given both to undergraduates and graduates in medicine, the great majority being medical students. A still more elaborate plan for instruction in diseases of the eye was begun at the New York Ophthalmic Hospital soon after its organization. The first annual report of the surgeons of that hospital for the year 1853 states that "Quite a number of practitioners from the city and county have also (in addition to medical students) visited the hospital from time to time for the purpose of witnessing treatment and methods of operation. In addition it will be seen in another part of the report that one of the surgeons has given a course of lectures on the anatomy, physiology and diseases of the eye to a large and highly respectable class of medical students and professional gentlemen during the present winter. It is the design of the surgeons to render it not only a hospital for the afflicted and destitute but an ophthalmic school to which students of medicine will resort in preference to other cities for the purpose of finishing their medical education."

The second annual report, 1854, gives "a catalogue of students and graduates in medicine amounting to sixty-five in all who are attending a course of lectures on ophthalmic surgery." In 1855 fifty to sixty students were in attendance. A testimonial was given to those who passed a satisfactory examination. The catalogue of 1858-59 claims that the school is the only one of its kind in America. In 1864 over five hundred students of medicine had availed themselves of the privileges of the hospital. As

in the case of the New York Infirmary the majority of those attending the school were undergraduates. A change of policy took place on or about the year 1877 for the report of that year stipulated that students in the school must have already the degree of doctor of medicine. On May 20, 1879 the State of New York authorized the College to confer the degree of *Oculi et auris chirurgus.* Some two hundred and fifty have received this degree which is at present conferred upon candidates who must be "doctors of medicine" and "who have attended at least 80 per cent of the scheduled work of the full course and on examination have attained a mark of 75 per cent in each subject scheduled."

No public courses were given so far as can be ascertained solely to graduates in medicine during the first 70 years of the century.

In 1871 Dr. L. Duncan Bulkley returned from post-graduate study in Vienna. There he had been so impressed with the method of the teaching of Hebra in whose clinic he had worked that he put it in operation for the benefit of physicians and students in the skin clinic at Bellevue Hospital of which he was temporarily in charge. He continued to do this for several years until he was appointed in charge of the Skin Clinic at the DeMilt Dispensary. (2)

At about the same time that Dr. Bulkley returned from Vienna, another young physician by the name of Clinton Wagner returned home after studying under Sir Morell Mackenzie at the London Throat Hospital in Golden Square. He was so much impressed with the character of the work done at this famous hospital that as soon as he was able to, he organized, in 1873, in New York an institution patterned after the London institution which he called the Metropolitan Throat Hospital. This was the first hospital in America to establish upon a regular basis the instruction of graduate physicians in the science of Rhino-Laryngology. "For many years it maintained a degree of excellence which constituted it easily the best. The reputation of Dr. Wagner and his admirable hospital soon

became known outside of New York, not only among those requiring the aid of the highest order of professional skill but also to advanced students and practitioners, who striving to improve their knowledge of the special art, sought the best and most inspiring instruction. His disciples came from all directions, not only in the United States but from Canada, and the Spanish American countries. Many of them attained eminence, such as John H. Lowman, of Cleveland, and Carlos Desvernine of Cuba.

In 1881, Dr. Wagner was among the first to enter upon the organization of the New York Post-Graduate Medical School and Hospital and was its first Professor in Laryngology and Rhinology. He retained that position until 1886 when he retired from practice. Meanwhile he had thoroughly established the prestige of the Metropolitan Throat Hospital and Dispensary, and had made it a model institution which rivalled the best clinics of its kind abroad." (3)

At the DeMilt Dispensary Bulkley met a number of men who were interested like himself in this method of teaching and who desired to make the DeMilt Dispensary a center for post-graduate work. As a result of their efforts, they organized themselves into a teaching staff. They printed schedules of the courses they gave which were published and appeared in the *New York Medical Journal.* These courses were in full operation during the years 1877 to 1879. Those who constituted the teaching body were G. M. Lefferts, H. T. Hanks, L. Duncan Bulkley, P. Brynberg Porter, Robert Campbell, Daniel Lewis, Lawrence Johnson, W. E. Bullard, N. B. Emerson, A. A. Smith, C. E. Billington, John S. Warren and Thomas E. Satterthwaite. Bulkley had already begun his teaching at the Dispensary in 1876 and according to Satterthwaite (4) inaugurated the movement. It is interesting to note that this pioneer in post-graduate teaching is still alive at the advanced age of eighty-two. He had printed circulars issued for the course which he gave, which lasted six weeks and for which he made a small charge. When the work was fully organized he gave free lectures in the DeMilt which were very

popular. Later he transferred the lectures to the New York Hospital and in 1898 began to give weekly clinics in the out-patient department of the New York Skin and Cancer Hospital. These lectures were largely attended and drew men from all over the country. They were continued until the beginning of the World War. (2)

In the later 70's and the early 80's Dr. D. Bryson Delavan was another one of those in the group who gave instruction at the DeMilt Dispensary. He advertised and gave private lessons in Laryngology charging $3.00 per lesson.

All the courses at the DeMilt were open both to graduates and undergraduates in medicine. To Bulkley's lectures at the New York Hospital and at the New York Skin and Cancer Hospital physicians only were admitted.

It is a common observation that great discoveries have been wont to find their conception in the minds of two or more men at the same time. So true is this of graduate education in New York that it is difficult or impossible at the present time to say to whom is due the credit of being the first to conceive it and put it in operation. Among those who returned from Europe impressed with the need of providing opportunities for graduate instruction in this country were graduates of the College of Physicians and Surgeons, among them Dr. Thomas Satterthwaite and Dr. Albert H. Buck. They conceived the idea of establishing a center for such work in connection with the College of Physicians and Surgeons and to this end were instrumental in incorporating the Alumni Association of the College of Physicians and Surgeons in 1873, with the hope that "the under graduate Faculty would favor the establishment of an extra mural corps of teachers for physicians only," as practiced in the Scotch Universities. The plan however did not go thru on account of the opposition of the Faculty. Disappointed in this direction, they proceeded to organize the teaching staff at the DeMilt Dispensary just referred to. Abandoning the plan of a center exclusively at the College of Physicians and Surgeons they

turned to the idea of making New York a great post-graduate center, the teachers coming from the three medical schools, New York University, Bellevue and College of Physicians and Surgeons. A committee was formed consisting of Dr. Thomas T. Sabine representing the College of Physicians and Surgeons, Dr. Alfred L. Loomis New York University, and Dr. William T. Lusk Bellevue, and an organization was effected which was called the New York Polyclinic. They held meetings from time to time but all efforts toward founding a post-graduate institution were without success. (4) At about the same time that this group of men was endeavoring to establish a graduate medical center in New York, another group was equally impressed with the fact that graduates in medicine who desired to pursue further special study had no opportunities in New York City other than those afforded by the hospitals and by undergraduate schools. They succeeded in impressing the desirability of meeting this want upon the Faculty of the New York University Medical College and in 1875 a post-graduate department was established there. (5) The Faculty of this Department consisted of seven professors who were permitted to grant certificates to graduates who attended and otherwise qualified. This Faculty was known as the Supplemental or Post-Graduate Medical Faculty. The names of the seven professors who constituted the Faculty were W. A. Hammond, James L. Little, D. B. StJohn Roosa, Fred R. Sturgis, M. R. Patten, J. W. S. Gouley and Henry G. Piffard. These courses were continued for seven years or until 1882. The conditions however under which the instruction was given were to them not at all satisfactory and in 1881 they demanded that they be allowed to hire a separate building, paying the rental from the fees of the students and that the instruction which was given to both undergraduate and post-graduate students should be exclusively for graduates in medicine. The University Faculty was not prepared to grant their demands and so on the 4th of April 1882 they resigned. (6-7) In Roosa's words: "Like Abraham we did not know the country to which we were going but the Lord

had ordered it and we went." "The most active leaders in this secession were the former Surgeon General of the Army, W. A. Hammond, D. B. StJohn Roosa, Frederick R. Sturgis, Montross A. Pallen and Henry G. Piffard." At first they endeavored to effect an affiliation with some University and actually made overtures to Princeton and Cornell with a view to establishing an undergraduate medical college where a course of post-graduate instruction would be given. This proved unsuccessful. As a result it was determined to establish in the city a school solely for post-graduate instruction. The scheme was actually the plan that those had in mind who had effected the paper organization known as the New York Polyclinic. On account of this name being already in use, the name New York Post-Graduate Medical School was adopted. The date of its birth according to the *Post Graduate* is April 4th, 1882, the date that the separation took place from the New York University. Frequent meetings were held, twenty-four in all during the summer and fall of that year and on June 27th at the residence of General Hammond a committee or organization was effected with Dr. Hammond as Chairman and Dr. Satterthwaite as Secretary. Dr. Sturgis, shortly afterward to be secretary of the Faculty, was the third member of this committee present.

This committee directed the policy of the new school for the first year. The *New York Medical Journal* of August 19th and 26th, 1882, contained announcements of the opening of the school which took place on the 6th of November 1882. The teaching faculty consisted of: James L. Little, W. A. Hammond, D. B. StJohn Roosa, Clinton Wagner, Henry G. Piffard, Frederick R. Sturgis, Montrose A. Pallen, Thomas E. Satterthwaite, Mary Putnam Jacobi, Edward C. Spitzka, William G. Morton, Herbert G. Lyttle, William H. Porter, Edward T. Ely, Whitfield Ward, W. T. Alexander, Henry Hughes, M. Josiah Roberts, Seneca D. Powell, Graeme M. Hammond, John N. Nesbit, C. A. Van Ramdohr, G. Fairfax Whiting, S. S. Burt and J. Hilgard Tyndale. Two days before the school was opened to students a formal opening took place at Chickering Hall.

(4) Difficulty was encountered in securing an incorporation of the young school on account of the opposition of the Attorney General of the State to granting a charter on the ground that the phrase "other institutions of learning" did not comprehend a post-graduate medical school, since none existed when the law was passed. Finally, however, a special law was enacted by the State Legislature to incorporate the School. The first course of instruction was given at the College of Pharmacy in East Twenty-third Street, November 6, 1882. There were six physicians in attendance and one hundred students matriculated during that year, 1882-83. Rice, at one time secretary of the Faculty states that: "The first annual announcement contained the names of nine professors, eight associate professors, and eight instructors. The school at first had no hospital of its own, and the teachers were compelled to supply their clinics with such patients as were able to walk to the building but the Faculty adhered to the fundamental principle upon which the school was organized, that all teaching should be actual demonstration of patients, and that didactic lecturing should have no part in its methods of instruction. From there it moved to a tenement house and in 1885 took an Old Ladies' Home, in Twentieth Street."

The school grew so rapidly that at the beginning of the fourth season still more commodious quarters were necessary which were secured at 226 East 20th Street. Two years after the opening of the school, the hospital department was opened with at first only a ward for surgical diseases of women. Gradually the capacity of the hospital was increased until all the building above the second floor was filled with patients.

Dr. D. B. StJohn Roosa, the President, was one of the outstanding figures in medicine in America during the latter half of the 19th century. He was born in Bethel, New York, September 4th, 1838 and was educated at Yale College and in medicine at the Medical Department of the New York University graduating from there in 1860.

He served as house Surgeon, New York Hospital, 1861-62. For two years he was assistant surgeon in the United States Army during the Civil War and later did post-graduate work in Vienna for a year. He early became distinguished as a specialist in Ophthalmology and Otology becoming the Professor of Diseases of the Eye and Ear, in the Medical Department of the New York University in 1875 and was the author of two well known text books on diseases of the eye and ear. He early took a deep interest in post-graduate medical education in America and his chief fame rests upon his long connection with it as president of the New York Graduate Medical School and Hospital. Dr. Roosa died March 8th, 1908.

Dr. James L. Little, one of the founders who died April 4th, 1886 conducted the first clinic at the Post Graduate School after its organization. The school continued to grow. It attracted to it the best teachers in the city and students from all over the country. In 1894 the original part of the present building was opened and in 1910 as a result of a gift of $2,000,000 from Fred Cooper Hewitt of Oswego, New York, the present addition was opened.

In the year 1909, six hundred and seventy-three (673) doctors were in attendance at the school. During the forty-four years of its existence twenty-five thousand three hundred seventy-three (25,373) physicians have received instruction at the school.

At the same time that most of the men whom we have spoken of were studying abroad or had just returned from Europe, there graduated (March 1869) from the medical department of the University of Louisville, one of the leading medical schools of the south, a man to whom equal credit should be given for the development of post-graduate instruction in this country, Dr. John Allen Wyeth. At that time "the teaching of surgery, medicine, obstetrics in the medical schools in the south was almost wholly didactic." There was no opportunity for hospital observation such as existed in New York at the New York Hospital. After his graduation Wyeth began the practice of

medicine in his native town in Alabama. In his own words "the experiment lasted six weeks. He had five patients and with each successive victim, he became more and more convinced of the truth of the maxim that a little learning is a dangerous thing. He had to quit, feeling that he did not know enough to justify him in placing himself in a position where the life, the health and happiness of human beings were in his hands. He needed to learn the practical application of the theory taught him at college. He determined to secure a post-graduate medical training." "He came to New York and graduated in medicine at Bellevue Medical College in 1873. He later was appointed assistant demonstrator of anatomy. He remained at Bellevue until 1877 in the capacity of prosector to the Chair of Anatomy and Assistant to the Professor of Pathology." His conviction that practical instruction was necessary in order to acquire a proper medical education led him to endeavor to establish an undergraduate medical school in the city where clinical instruction would be a prominent feature. This he was unable to bring about and finally abandoned the undergraduate feature of the plan and in 1881-82 (there is a dispute in regard to the year) the Polyclinic was organized. (9) According to Satterthwaite, "The New York Polyclinic, as it was called in 1882, was actually a continuation, certainly so far as the name is concerned, of the New York Polyclinic that had for years been a skeleton organization, of which Dr. W. T. Lusk and Dr. F. A. Castle, with the writer, had been members. But at its origin as the Polyclinic of 1882, these names were absent. I am able to say that Dr. Virgil P. Gibney told me (on October 22, 1907) that in the spring of 1882 he received from me the scheme of the original Polyclinic. It formed the basis of the Polyclinic of that year." (4)

The school was opened in November, 1882. The first session was held in the ground floor of 213-16 East 34th Street. The original faculty of the Polyclinic was a brilliant one—it comprised Drs. James R. Leaming, John H. Ripley, E. Darwin Hudson, Louis Elsberg, Landon Carter Gray, Richard C. Brandies, A. R. Robinsons, Edward B.

Bronson, George R. Fowler, John A. Wyeth, A. C. Gerster, Paul F. Munde, W. Gill Wylie, Emil Gruening, David Webster, V. P. Gibney, and Charles F. Stillman.

Eighteen students were in attendance at the opening session with one hundred eighty-two registered during the year. The school under the leadership of Wyeth at once demonstrated the need of its existence and has attracted hundreds of medical men. In 1910 it erected the twelve story hospital at 335-355 West 50th Street which it occupies at present. In 1922 Dr. Wyeth died. Apart from the honor that is due him of being one of the founders of graduate education in America, he is distinguished as being of the leading surgeons of New York of his time.

The Polyclinic now has a staff of two hundred seventy-five physicians and surgeons. During the past year it has taught one hundred ninety-nine graduate student physicians and its census for the current year will greatly exceed that number.

The Post-Graduate and Polyclinic Medical Schools and Hospitals were of inestimable value in affording opportunities to acquire the most recent knowledge in the various fields of medicine and during the many years of their existence these opportunities have been taken advantage of by hosts of men from all over the country. They represent however only two hospitals in the great metropolis. More and more the idea impressed itself upon those who gave the matter thought that the rich opportunities for graduates in medicine afforded by the many hospitals in the city should be made known to the profession at large. This resulted in the organization on December 16, 1912 of the "Society for the Advancement of Clinical Study in New York" of which Dr. Charles N. Dowd was the Chairman. It first undertook to establish a Bureau of Clinical Information in the New York Academy of Medicine. A year later the society prepared and published a booklet of the fixed clinics of hospitals where visitors were welcome. At about that same time it began to publish a daily bulletin of surgical clinics. In 1917 it organized a

series of medical clinics which were given weekly and announced in a separate weekly bulletin. In 1922 the society undertook to gather information regarding post-graduate medical study in other cities. All the activities were carried on and gradually expanded until the society ended its existence in January 1924 merging with the Committee on Medical Education of the Academy. In 1919 a still more ambitious attempt was made to advance the cause of post-graduate medical education in New York in the organization of the New York Association for Medical Education. The principal objects of this association were set forth in its preliminary announcement as follows:

The proposal of a small group of physicians, surgeons and medical teachers of New York to establish a central clearing house for medical education has so favorably impressed their colleagues that what has been for years past a dream and a hope has now become an accomplished fact. The medical profession has developed within itself an active organization to stimulate, obtain support for, and expand medical education for students and graduates of medicine in the interest of an ultimate better service to the public. The scheme included a committee on education comprising the deans of the four undergraduate medical schools and representatives of the undergraduate institutions whose duty it was "to prepare plans and standards that shall insure a permanent improvement in the character of medical teaching in New York City; to keep itself informed concerning and to pass on the qualifications of teachers and the character of the courses they offer to graduate students of medicine, and to observe and regulate the manner in which engagements are met by those offering courses under the auspices of the Association." The Association stressed as the first and most urgent educational problem before it the development of medical education in New York City. The first president of the association was Dr. Wendell C. Phillips who was succeeded by Dr. Haven Emerson. Dr. Henry O. Reik was chosen for the first year of its existence as executive secretary. The association got out several bulletins setting forth in detail

the opportunities for graduate instruction in New York City. It maintained a bureau at the New York Academy of Medicine and thru its secretary furnished information to all inquiries as to courses and places of study. It continued actively in operation until in 1924 when it was merged with the Committee on Medical Education of the New York Academy of Medicine.

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SECOND GRADUATE FORTNIGHT OF THE NEW YORK ACADEMY OF MEDICINE

OCTOBER 7 TO 19, 1929

"Functional and Nervous Problems in Medicine and Surgery"

Evening meetings at the Academy. The evening meetings will begin promptly at 8.30. No tickets of admission will be required.

Tickets for afternoon clinics. Attendance at the afternoon hospital clinics which have been arranged for the Fortnight will be controlled by clinic tickets, for which advance registration is requested. Clinic tickets will be mailed to those who make reservations or may be called for at the Academy (Registration Bureau).

Additional clinics. Besides the specially arranged hospital programs, the regularly announced non-operative clinical conferences will be held as usual, *both mornings and afternoons* during the Fortnight, in over forty teaching hospitals of the city. No registration or tickets will be required for these clinics.

A complete program announcing clinics in hospitals, names of clinicians, and the program of evening meetings to be held at the Academy, will be mailed to the Fellows and may also be obtained on request.

LIBRARY NOTES

VISIONING OUR PERIODICALS

The simple little word vision calls forth the idea of wonderful possibilities. With the vision of the eye man sees all the beauties of nature spread out before him by a munificent Providence for his joy and happiness. But it is the vision of the mind which introduces the ideas from which progress and achievement result.

When therefore through several decades one has visualized a specific branch of human endeavor, as the desire to assist the profession of medicine in its efforts to arrest human suffering, one is amazed at the vision of the early builders of medical progress. Take for example our own favored Academy. For its beginning—a small number of doctors gathered together for the purpose of discussing means to further medical education and the providing of a medical library. In imagination one can see those worthy Founders planning what has proved to be our destiny—this useful working machine for forwarding medical progress throughout the intelligent management of its various committees. The library being specifically mentioned by the Founders, as of prime importance, has received the main portion of consideration since the Academy's beginning. In looking over the Trustees' minutes, one is impressed by the efforts continually made to collect funds for books and periodicals. "Aye, there's the rub," periodicals! Therein are to be found the notations of researches made all over the world, whereby students may verify some small point that has been searched for through all the leisure possible for years! How inexpressibly valuable the periodical and what havoc it makes with budgets. The late Nicholas Senn, after various futile attempts to see a reference, came to our library for a number of "Lyon Chirurgical." The attendant, knowing that we did not subscribe at that time for the journal, went to the stacks where were kept imperfect files. And there the only number of "Lyon Chirurgical" we had, was the one wanted! On

being told of the fact, Dr. Senn remarked, "I thought you took everything." "We do," he was told, "Everything we have the money to pay for." And that about expresses the state of affairs to-day. Our great City of New York, the metropolis of the United States, should have on its shelves in its medical library, so beautifully housed and completely equipped by its generous benefactors, every periodical that the researchers in our Commonwealth might need. When it is realized what an army of physicians, chemists, botanists, dentists, physicists, clergymen and dramatists have been helped in their researches by the use of our library, its value is pretty positively demonstrated.

We need more money while the sales catalogues are advertising rare and useful files of periodicals.

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LIBRARY HOURS DURING THE SUMMER

From June 15 until September 15 inclusive, the Library will be open on week days from 9 a. m. to 5 p. m., on Wednesdays from 9 a. m. to 10:30 p. m., and on Sundays from 10 a. m. to 5 p. m.

OBITUARY

DR. REGINALD HALL SAYRE

The death of Doctor Sayre takes from the roll of active members a name first put there by the distinguished father on the organization of the Academy in 1847. Forty years later Reginald Sayre was admitted to the Fellowship and he too took a prominent part in the scientific and administrative work. For about half of the forty-two years of his membership he held office in the Academy. He was Assistant Secretary from 1892 to 1894, Recording Secretary 1895-97 and concurrently, a member of the important Committee on Admission, being the chairman in 1899.

Then in 1900 he was chosen Treasurer for the Trustees and served till December, 1905, when that office was abolished and he was elected Treasurer of the Academy and served eleven years more till 1917. So he was for sixteen years the financial officer—a tribute, certainly, to his judgment and probity. During this incumbency the first steps were taken looking to the broadening out of the field of activity of the Academy, the purchase of a site and the erection of a new building and Doctor Sayre was one of those very active workers who composed the Extension Fund Committee which raised the first $140,000. In 1919 he was elected Vice-President to fill the vacancy caused by the death of Doctor Cragin. It might seem that he sought office, but he did not, he was just the willing horse, always ready.

His especial interest in the Academy was, of course, with what concerned orthopaedic surgery. He was often a contributor and in regular attendance at the section meetings.

In 1891-92 he rose to official distinction in the American Orthopaedic Association by his election to the Vice-Presidency and in 1893 he was an Honorary Vice-President of the Orthopedic Section of the Pan-American Medical Congress, and this year he was Vice-President of the New York Pathological Society also.

Reginald Hall Sayre derived from old American stock—from Thomas Sayre of Southampton, New York, 1640, and from John Hall of Charlestown, Massachusetts, 1630. His father, Lewis Albert Sayre, was born in New Jersey, his mother, Eliza Ann Hall, in Connecticut and he himself in New York City on October 18, 1859. He had two brothers, Charles Henry Hall Sayre, (1850-1880) and Lewis Hall Sayre, (1851-1890) both of whom were graduated at the Bellevue Hospital Medical College, and one sister, Miss Mary Hall Sayre, who survives him. He attended the Churchill & Maury School in this city, entered Columbia College when he was eighteen and was graduated A.B. in 1881 with his mind fully made up to study law, there being already enough surgeons in the family and he actually did matriculate at the law school in Great Jones Street. Earnest talks with his brother Lewis however, finally induced him to turn to medicine, and there he certainly belonged. He entered Bellevue Hospital Medical College in the Fall of 1881. In the hospital examinations in 1884 he obtained the

choice of services. To the surprise of his fellows, because he was destined for orthopaedics, he chose the medical service—he was determined to start right at any rate. As interne he was junior to Hermann M. Biggs; the visiting staff of the Third Division was Austin Flint the senior, Edward G. Janeway, A. A. Smith and William T. Lusk. Sayre's desire was to get a broad, general training at Bellevue Hospital.

At this time Professor Lewis A. Sayre was a man of international repute with a very large private consultation practice, patients coming from far and near, having joint affections of every description, and his spacious office at 30th Street and Fifth Avenue was, in itself, it might be said, an institute of orthopaedic surgery. Reginald now joined his brother Lewis as junior assistant and his career spread out before him. Six years later his brother died. He assisted his father, also, in teaching at the college, attending the Bellevue Out-Patient Department, and that assiduously. He was like his father, a clinical rather than a didactic teacher; he succeeded him as Professor of Orthopaedic Surgery. Last May the Council of the New York University conferred on him the title of Emeritus Professor. He was a friend of the students and was one of the early supporters of the Medical Students' Club movement.

Sayre was one of the founders of The Society of Alumni of Bellevue Hospital and President in 1902-10. In his address to the Society he said: "A man should never overwork himself . . . . as it is so easy to acquire a way of being slipshod and slovenly from lack of time. . . ." He did overwork himself. He was deliberate, not a fast worker and painstaking to an extreme in his attention to patients; apparently he thought himself a man with unlimited power of endurance. Perhaps this came about from his early training. At Columbia he entered into athletic and other activities with characteristic ardor. He received a scholarship in chemistry, he was a member of Phi Beta Kappa, a member of the class crew, a member of the 'Varsity track team and he held the championship in the Intercollegiate mile walk.

In fact he had many interests besides his profession. He was a lover of horses. He joined Troop A though he was not an accomplished rider, and remained with the Troop for years. He owned several fine horses and drove a very smart team in making professional rounds and on the road. One of his friends, himself an expert horseman, told the writer that "Sayre could manage any horse; he could put any horse into the shafts for he had a 'beautiful hand' and he was absolutely fearless."

He was renowned for his marksmanship. He was the champion All-America pistol shot and he captained four Olympic Pistol Teams in 1908, 1912, 1920 and 1924. A circumstance that occurred some fifteen years ago shows his conscientious thoroughness. He was Inspector of Small-Arm Practice, New York National Guard, and, thinking he ought to become adept with the broad-sword, he took this up and in a tournament reached the semi-finals, but an attack of influenza intervened and he surrendered,

not to his doctor, but to the broad-sword which he could not lift though he had it in bed with him.

In 1917 he acted as Division Surgeon, N. G. N. Y. with rank of Lieut. Colonel; during the war he was in charge of orthopaedic instruction to medical officers at the New York University.

He was a public-spirited citizen, taking a deep interest in political questions and a Democrat up to 1896, but the "Cross of Gold" speech made him an independent voter. He was a member of the City Club. He formed his own opinions.

Doctor Sayre began rather early to write. Seven months after he completed his interneship he read a paper at the Academy before the Orthopaedic Section on "The Immediate Restoration of Parts to the Normal Position after Tenotomy"* a very well-written and thought-out paper in which he boldly takes a position contrary to the opinions generally held at the time. Most of his writing was done when he was young; he wrote very little after 1910 and he wrote well. In talk he used many colloquialisms and, particularly with "run-about" children, he had rhymes and jingles at his tongue's end and he made good use of them; he could manage a fractious child as well as he could a fractious horse. Withal he possessed great mechanical skill, he loved his work and his practice was based on scientific knowledge for he kept well up-to-date; ethical conduct was natural to Sayre.

He started in life well on the road to success and by his own ability he reached and maintained a place of the highest worth in the minds and the hearts of his colleagues. Fraternal is a word that can well be applied to Reginald Sayre. He was a man of strong individuality, generous, large-hearted, unsparing of himself, devoted to his friends and he was held in deep affection by them. For much that he did his remuneration consisted in the satisfaction that comes from work well done and the gratitude and lasting regard of his patients.

Doctor Sayre was a Fellow of the American College of Surgeons, the American Medical and the American Orthopedic Associations (President of the latter in 1904). The hospitals where he did most of his work were Bellevue and St. Vincent's. He was Assistant Visiting Surgeon to Bellevue till a few months ago when he became Consulting Surgeon. He was Consulting Surgeon to St. Vincent's since 1910, Hackensack (1891), Hospital for Crippled Children, Newark (1897), Mountainside, Montclair (1898), N. Y. State Orthopedic, West Haverstraw (1900), Englewood (1901), Hospital for Deformities (1908) and Flushing (1914); also the West Side Hospital and Dispensary.

He belonged to the University and the Columbia University Clubs, the Society of the Early 80's (Columbia), Pilgrims of the United States, Coeur de Lion Commandery, Knights Templar, Jerusalem Chapter, Royal Arch Masons and Kane Lodge; the Army & Navy Club, U. S. Rifle Association,

* Alabama M. & S. Jour., July, 1886.

Manhattan Rifle and Pistol Association and the New York Athletic Club of which he was a Life Member.

The death of Doctor Reginald Sayre was entirely unexpected. It was due to myocardial degeneration and happened suddenly on May 29, 1919, in the course of a mild attack of facial erysipelas of two days duration.

ROBERT J. CARLISLE.

DEATHS OF FELLOWS OF THE ACADEMY

EDWARD HAMILTON SQUIBB, M.D., 184 Columbia Heights, Brooklyn, New York; graduated in medicine from the College of Physicians and Surgeons, New York City, in 1881. Dr. Squibb was a Fellow of the American Medical Association and a member of the County and State Society. He was elected a Fellow of the Academy October 15, 1896; died, July 6, 1929.

WILLIAM HENRY LUCKETT, M.D., 18 West 87 Street, New York City; graduated in medicine from the College of Physicians and Surgeons, New York City, in 1894. Dr. Luckett was a Fellow of the American Medical Association, a Fellow of the American College of Surgeons and a member of the County and State Society. He was Directing Surgeon to the Lutheran Hospital and Consulting Surgeon to the Harlem Hospital. Dr. Luckett was elected a Fellow of the Academy March 3, 1904; died, July 20, 1929.